THIRD PARTY COLLECTION PROGRAM - INSURANCE INFORMATION

(Read Privacy Act Statement on back before completing this form.)

REPORT CONTROL SYMBOL

Form Approved
OMB No. 0704-0323
Expires Jun 30, 2000

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THIS ADDRESS. RETURN COMPLETED FORM TO REQUESTING MILITARY TREATMENT FACILITY.

SECTION I - PATIENT INFORMATION

1. NAME *(Last, First, Middle Initial)*			2. PATIENT SSN	3. DATE OF BIRTH *(YYYYMMDD)*
4. ADDRESS			**5. TELEPHONE NUMBER**	
a. STREET *(Include apartment number)*			a. HOME ( )	b. OFFICE ( )
b. CITY	c. STATE	d. ZIP CODE	6. SPONSOR'S BRANCH OF SERVICE	
7. FAMILY MEMBER PREFIX/SPONSOR SSN			8. RELATION OF PATIENT TO INSURED	

9. IS PATIENT'S CONDITION RELATED TO AN ACCIDENT *(X one)*		YES *(Complete a. - e.)*		NO *(Complete d. and e.)*	
a. TYPE OF ACCIDENT *(X one) (Comply with information requirements as stated in DoDI 6010.15)*		b. DATE OF ACCIDENT *(YYYYMMDD)*	c. HOUR	d. DATE OF ADMISSION/ VISIT *(YYYYMMDD)*	e. HOUR
☐ AUTO ACCIDENT ☐ OTHER *(Type)*_____					

SECTION II - INSURANCE CARRIER INFORMATION *(Complete for all Health Insurance policies and employers.)*

10. EMPLOYER OF POLICY HOLDER

a. NAME			b. TELEPHONE NUMBER ( )
c. ADDRESS			
(1) STREET *(Include apartment or suite number)*	(2) CITY	(3) STATE	(4) ZIP CODE

11. PRIMARY MEDICAL INSURANCE POLICY

a. INSURANCE TYPE *(X one)*

☐ GROUP HEALTH PLAN ☐ INDIVIDUAL ☐ SUPPLEMENTAL MEDICARE A ☐ SUPPLEMENTAL MEDICARE B

b. NAME OF POLICY HOLDER *(Last, First, Middle Initial)*	c. SSN OF POLICY HOLDER	d. GROUP POLICY NUMBER	e. INDIVIDUAL POLICY NUMBER

f. INSURANCE COMPANY			g. FAMILY MEMBERS COVERED BY THIS POLICY		
(1) NAME	(2) TELEPHONE NUMBER ( )		(1) NAME *(Last, First, Middle Initial)*	(2) DATE OF BIRTH *(YYYYMMDD)*	(3) SSN
(3) STREET ADDRESS *(Include apartment or suite number)*					
CITY	STATE	ZIP CODE			

12. OTHER MEDICAL INSURANCE POLICIES *(Use additional pages as necessary)*

a. INSURANCE TYPE *(X one)*

☐ GROUP HEALTH PLAN ☐ INDIVIDUAL ☐ SUPPLEMENTAL MEDICARE A ☐ SUPPLEMENTAL MEDICARE B

b. NAME OF POLICY HOLDER *(Last, First, Middle Initial)*	c. SSN OF POLICY HOLDER	d. GROUP POLICY NUMBER	e. INDIVIDUAL POLICY NUMBER

f. INSURANCE COMPANY			g. FAMILY MEMBERS COVERED BY THIS POLICY		
(1) NAME	(2) TELEPHONE NUMBER ( )		(1) NAME *(Last, First, Middle Initial)*	(2) DATE OF BIRTH *(YYYYMMDD)*	(3) SSN
(3) STREET ADDRESS *(Include apartment or suite number)*					
CITY	STATE	ZIP CODE			

SECTION III - PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC, Sec. 1095; EO 9397.

PRINCIPAL PURPOSE(S): Information will be used to collect from private insurers for medical care provided to military dependents and retirees. Such monetary benefits accruing to the Military Treatment Facility will be used to enhance health care delivery in the Military Treatment Facility. Information will also be used by Military Treatment Facility staff and TRICARE Support Office Contractors to determine eligibility for care, deductibles, and co-shares.

ROUTINE USE(S): The information on this form will be released to your insurance company, to staff of facilities of the uniformed services, and to health care providers to support claims for reimbursement.

DISCLOSURE: Voluntary; however, failure to provide complete and accurate information may result in disqualification for health care services from facilities of the uniformed services.

SECTION IV - RELEASE AND ASSIGNMENT

I acknowledge that portions of my medical records necessary to support claims for reimbursement for the cost of care rendered may be released to my insurance carriers.

I acknowledge that the authority to bill third party payers has been conveyed to the medical facility within the Department of Defense by Title 10 U.S. Code, Section 1095, and that no personal entitlement to reimbursement or payment has been granted to me by virtue of this act.

I hereby acknowledge that the proceeds of any and all benefits shall be paid directly to the facility of the Uniformed Service for hospitalization or outpatient services provided me and/or my family member.

SECTION V - CERTIFICATIONS

I certify that the information on this form is true and accurate to the best of my knowledge.

13. PATIENT OR ADULT FAMILY MEMBER/SPONSOR	
a. SIGNATURE	**b. DATE SIGNED** *(YYYYMMDD)*
14. CLERK	
a. SIGNATURE	**b. DATE SIGNED** *(YYYYMMDD)*

SECTION VI - REGISTRATION VERIFICATION

NOTE: Verification of insurance coverage shall be made upon the occasion of each admission or outpatient visit to the Military Treatment Facility. Any time information on this form is changed a new signature must be obtained. Annually, on the first visit after twelve months have passed since the patient's signature was first obtained, a new form must be completed and signed.

I certify that the information on this form has been verified on the date(s) specified below, and that all information is true and accurate to the best of my knowledge.

15. FIRST VERIFICATION	
a. SIGNATURE	**b. DATE SIGNED** *(YYYYMMDD)*
16. SECOND VERIFICATION	
a. SIGNATURE	**b. DATE SIGNED** *(YYYYMMDD)*
17. THIRD VERIFICATION	
a. SIGNATURE	**b. DATE SIGNED** *(YYYYMMDD)*